TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #15-38(E)

DIGEST

Temporarily adds provisions affecting applicants, members, and providers concerning eligibility, enrollment, benefits, and policy for HIP 2.0. Temporarily repeals 405 IAC 9. Statutory Authority: IC 12-15-44.2-19. Effective February 1, 2015.

SECTION 1. **(a) Notwithstanding any other section under 405 IAC, this document applies to individuals enrolled in the plan as defined in SECTION 2(jj) of this document.**

(b) Under IC 12-15-44.2, the office hereby adopts and promulgates this document to:
(1) ensure the:
(A) efficient;
(B) economical;
(C) medically reasonable; and
(D) quality;
operations of the plan;
(2) support:
(A) healthy behaviors; and
(B) personal responsibility;
(3) safeguard against:
(A) overutilization;
(B) fraud;
(C) abuse; and
(D) the utilization of services and supplies that are not:
(i) covered under the plan; or
(ii) medically reasonable and necessary.

(c) The plan shall be operated in compliance with approved federal waiver and expenditure authorities and special terms and conditions established by the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS).

(d) The expansion of the plan to individuals eligible under SECTION 6 of this document is conditioned upon:
(1) The approval of the Healthy Indiana Plan 2.0 Section 1115 waiver application by CMS.
(2) The increased federal medical assistance percentage available to individuals defined in 42 CFR 435.119, as provided in Section 1905(y) of the Social Security Act.
(3) The designation of hospital assessment fee funds as set forth in IC 16-21-10, to support the plan beginning in calendar year 2017.

SECTION 2. **(a) The definitions in this SECTION apply throughout this document.**

(b) "Alternative benefit plan" means an alternative benefit plan approved by CMS that meets the requirements as set forth in 42 U.S.C. § 1396u-7 et seq.

(c) "Applicant" means an individual for whom coverage under the plan is requested.

(d) "Benefit period" means the continuous period of plan eligibility. Subject to any exceptions listed in this document, the period of plan eligibility is twelve (12) months.

(e) "Conditionally eligible" or "conditionally eligible individual" means a plan applicant who:
(1) has been determined eligible for the plan by the division; and
(2) is not yet able to receive coverage under HIP Basic, HIP Plus, HIP State Plan Basic, or HIP State Plan Plus.

(f) "Copayment" means a fixed amount charged to a member by the provider for certain services at the time the services are provided.

(g) "Covered service" means a service provided to a member for which payment is available under the plan, subject to the limitations set forth in this document and in:
(1) manuals;
(2) bulletins; or
(3) other documentation;
published by the insurers and office.

(h) "DEC" means a designated enrollment center authorized by the division to:
(1) accept applications; and
(2) complete initial intake processing on applications.

(i) "Deductible" means the amount of covered medical services for which the member is responsible. The amount of the deductible for the plan is two thousand five hundred dollars ($2,500) for the benefit period.

(j) "Division" means the division of family resources or its designee.

(k) "Emergency medical condition" means a medical condition as set forth in Section 1867(e)(1) of the Social Security Act.

(l) "Emergency services" means covered services, including inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition.

(m) "Enrollment broker" means an entity that contracts with the state to:
(1) inform applicants and members about; and
(2) enroll applicants and members with;
insurers participating in the plan.

(n) "Family planning services" means services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy including, but not limited to, birth control pills and nonoral contraceptives. The term also includes sexually transmitted disease testing. Elective abortions and abortifacients are excluded from the definition of family planning services.

(o) "Family planning services program" means the Medicaid category set forth at IC 12-15-46-1.

(p) "Fast track prepayment" means an optional ten dollar ($10) POWER account contribution, which, upon the division's eligibility determination, is either:
(1) refunded to a pending applicant determined ineligible for the plan; or
(2) applied toward the member's required POWER account contribution in the case of a pending applicant determined eligible for the plan.

(q) "Federal income poverty level" or "FPL" means the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2).

(r) "Federal marketplace" means an American health benefit exchange or online marketplace for health insurance operating in Indiana under the Patient Protection and Affordable Care Act.

(s) "Healthy Indiana Plan Basic" or "HIP Basic" means the benefits under the plan, subject to copayments as set forth in SECTION 45(b) of this document, that are provided to individuals with household income at or below one hundred percent (100%) of the FPL when such individuals do not make the required contributions to their POWER account as set forth in SECTION 45(a) of this document. HIP Basic is an HHS secretary-approved alternative benefit plan as set forth in Section 1937 of the Social Security Act.

(t) "Healthy Indiana Plan Plus" or "HIP Plus" means the enhanced benefits package available to individuals with household income up to and including one hundred thirty-three percent (133%) of the FPL who make the required POWER account contributions as set forth in SECTION 45(a) of this document. HIP Plus is an HHS secretary-approved alternative benefit plan as set forth in Section 1937 of the Social Security Act.

(u) "Healthy Indiana Plan State Plan" or "HIP State Plan" means the benefits that are, at a minimum, no less than the benefits offered in the Medicaid state plan or HIP Plus, and that are available to the following members who are enrolled in the plan:

(1) Medically frail.

(2) Section 1931 parents and caretakers relatives.

(3) Members eligible for transitional medical assistance.

(4) Low income dependents.

(v) "HIP State Plan Basic" means the benefits, subject to copayments as set forth in SECTION 45(b) of this document, available to HIP State Plan members with household income at or below one hundred percent (100%) of the FPL when such individuals do not make the required contributions to their POWER account as set forth in SECTION 45(a) of this document.

(w) "HIP State Plan Plus" means the benefits available to HIP State Plan members with household income up to and including one hundred thirty-three percent (133%) of the FPL who make the required POWER account contributions as set forth in SECTION 45(a) of this document.

(x) "Household" means the composition and family size of a household as set forth in 42 CFR 435.603(f).

(y) "Household income" means the sum of the modified adjusted gross income (MAGI) of every individual included in the individual's household as set forth in 42 CFR 435.603.

(z) "Indian" means any individual defined at 25 U.S.C. § 1603(13) or 25 U.S.C. § 1603(28) or whom the division has determined eligible as an Indian under 42 CFR 136.12.

(aa) "Insurer" means a health insurer or health maintenance organization that has contracted with the office to provide a high deductible health plan and POWER account to individuals enrolled in the plan.

(bb) "Low income dependent" means a dependent either nineteen (19) or twenty (20) years of age who maintains primary residence in the home of a parent or caretaker relative and meets the Section 1931 parent and caretaker relative income criteria.

(cc) "Medically frail" means an individual who, in accordance with the process in SECTION 8 of this document, is determined to have any one (1) of the following as set forth in 42 CFR 440.315(f):

(1) A disabling mental disorder.

(2) A chronic substance abuse disorder.

(3) A serious and complex medical condition.

(4) A physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one (1) or more activities of daily living.

(dd) "Medically necessary service" means a covered service that, in a manner consistent with accepted standards of medical practice, is reasonably expected to:

(1) prevent or diagnose the onset of:

(A) an illness;

(B) an injury;

(C) a condition;

(D) a primary disability; or

(E) a secondary disability;

(2) cure, correct, reduce, or ameliorate the:

(A) physical;

(B) mental;

(C) cognitive; or

(D) developmental;

effects of an illness, an injury, or a disability; or

(3) reduce or ameliorate the pain or suffering caused by:

(A) an illness;

(B) an injury;

(C) a condition; or

(D) a disability.

(ee) "Member" means an individual:
(1) whom the division has determined to be eligible for the plan;
(2) who is able to receive coverage under HIP Basic, HIP Plus, HIP State Plan Basic, or HIP State Plan Plus; and
(3) who is not conditionally eligible.

(ff) "Modified adjusted gross income" or "MAGI" means income calculated using the financial methodologies defined in Section 36B(d)(2)(B) of the Internal Revenue Code. MAGI-based income is calculated in accordance with 42 CFR 435.603(e).

(gg) "Nonemergency transportation services" are defined as transportation services that are unrelated to an emergency medical condition as defined in subsection (k).

(hh) "Office" means the Indiana family and social services administration, its offices, divisions, or designee.

(ii) "Pending applicant" means an applicant whose application has been received by the division and who has not yet been determined eligible for the plan, but who has been determined by the division to meet the following initial criteria:
(1) Be at least nineteen (19) years of age and less than sixty-five (65) years of age.
(2) Not be a pregnant woman.
(3) Not be enrolled in the federal Medicare program, 42 U.S.C. § 1395 et seq.
(4) Not be a former foster youth.
(5) Not be determined disabled.

(jj) "Plan" means the Healthy Indiana Plan or HIP as established by a HHS approved Section 1115 demonstration waiver and IC 12-15-44.2 that provides health care benefit packages to eligible individuals through a high deductible health plan paired with a personal health spending account called a POWER account.

(kk) "Plan reimbursement rate" means the amount of reimbursement insurers pay to providers participating in the plan. This amount shall be:
(1) established by the secretary; and
(2) based on a Medicaid reimbursement formula that is:
(A) comparable to the federal Medicare reimbursement rate for the service provided; or
(B) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate.

(ll) "POWER account" or "personal wellness and responsibility account" means a personal health spending account used to pay a member's deductible for plan covered benefits and services.

(mm) "Pregnant women" means a woman who is pregnant and who otherwise meets the HIP eligibility criteria set forth in SECTION 6 of this document.

(nn) "Pregnant women Medicaid category" refers to the Medicaid benefits category under the state plan for which a pregnant woman is eligible.

(oo) "Preventive care services" means care that is provided to a member to:
(1) prevent disease;
(2) diagnose disease; or
(3) promote good health.

(pp) "Prior authorization" or "PA" means the procedure for the insurer's prior review and authorization, modification, or denial of coverage for medical services and supplies within plan allowable limitations, based upon medical necessity and other criteria as established by one (1) of the following:
(1) The office.
(2) Insurers, subject to approval by the office.

(qq) "Provider" means:
(1) an individual;

(2) a state or local agency; or
(3) a corporate or business entity;
that meets the requirements of 405 IAC 5-4-1. A provider enrolled as a Medicaid provider under 405 IAC 5-4 is eligible to participate in the plan.

(rr) "Qualified presumptive eligibility provider" means:
(1) a hospital;
(2) federally qualified health center;
(3) rural health center;
(4) community mental health center; or
(5) health department;
authorized by the office to determine presumptive eligibility subject to the requirements of 42 CFR 435.1103 and 42 CFR 435.1110.

(ss) "Secretary" means the secretary of the Indiana family and social services administration.

(tt) "Section 1931 parent and caretaker relative" means an individual defined in 42 CFR 435.4 who meets the following income criteria:

Family Size	Monthly Income Amount
1	$152
2	$247
3	$310
4	$373
5	$435
6	$498
7	$561
Each additional	$63

(uu) "State" means the executive branch of the state of Indiana.

(vv) "Transitional medical assistance" means the extension of eligibility for medical assistance for Section 1931 parents and caretaker relatives in accordance with Section 1925 of the Social Security Act.

SECTION 3. **(a) An applicant seeking coverage under the plan must submit an application on the form approved or accepted by the office.**

(b) An application may be submitted through:
(1) the division;
(2) a DEC;
(3) an online method determined by the division; or
(4) the federal marketplace.

(c) In order to be screened for medically frail eligibility under SECTION 20 of this document, an applicant must answer the health screening questions on the application form regarding the applicant's health status. If the applicant does not complete the health screening questions on the application, the division will review the application for eligibility in the plan but will not review it initially for medically frail eligibility.

(d) The following individuals may sign an application:
(1) The applicant.
(2) The applicant's next of kin.
(3) The applicant's authorized representative.

(e) An enrollment broker may assist plan applicants in choosing an insurer.

(f) The office will assign an applicant to an insurer if such applicant does not choose an insurer on the application.

(g) A DEC that completes initial intake processing for an applicant shall forward the completed

application and all required documentation materials to the division.

(h) The date of application is determined as follows:
(1) In the case of an application filed with the division, the date a signed application is received by the division.
(2) In the case of an application filed at a DEC, the date a signed application is received by the DEC.
(3) In the case of an application filed via the federal marketplace, the date provided to the state by the federal marketplace.

(i) If an applicant fails or refuses to provide information or verification of information required to determine the applicant's eligibility for the plan, the applicant shall be ineligible and the division shall deny the application. Prior to denying an application under this SECTION, the division shall provide the applicant written notice of the specific information or verification needed to determine eligibility. The division will deny an application if the information or verification is not received by the division within thirteen (13) calendar days of the date of the notice. If a deadline falls on a weekend or holiday, the deadline for receiving the information shall be the next business day.

(j) The division shall send an eligibility determination notice to the applicant within forty-five (45) days of the date of the application.

SECTION 4. **(a) This SECTION applies to all applicants for the plan until March 31, 2015, 11:59 p.m. This SECTION will no longer apply to a pending applicant as defined in SECTION 2(ii) of this document on and after April 1, 2015.**

(b) An eligible applicant will be considered conditionally eligible for HIP Plus unless such individual is eligible for HIP State Plan benefits.

(c) A conditionally eligible individual, in order to receive HIP Plus or HIP State Plan Plus benefits, must make the initial contribution to his or her POWER account in the amount set forth in SECTION 45(a) of this document within sixty (60) days of the office's eligibility determination.

(d) A conditionally eligible individual with household income above one hundred percent (100%) of the FPL will:
(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which he or she makes his or her initial POWER account contribution; or
(2) in the event such individual does not make his or her initial POWER account contribution within the sixty (60) day payment period described in subsection (c), no longer be conditionally eligible.

(e) A conditionally eligible individual with household income at or below one hundred percent (100%) of the FPL will:
(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which he or she makes his or her initial POWER account contribution; or
(2) in the event such individual does not make his or her initial POWER account contribution within the sixty (60) day payment period described in subsection (c), begin HIP Basic or HIP State Plan Basic benefits, as applicable, the first day of the month in which the office determines nonpayment.

(f) Subsections (b) through (e) do not apply to an Indian. An eligible Indian will begin receiving HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the eligible individual applied for the plan.

SECTION 5. **(a) This SECTION applies on and after April 1, 2015.**

(b) Upon receipt of an application but prior to determining eligibility, the office will assign the pending applicant to either:
(1) the insurer selected on the application; or
(2) an insurer assigned to an individual in accordance with SECTION 3(f) of this document.

(c) The insurer will send the pending applicant a ten dollar ($10) fast track prepayment invoice that is due within sixty (60) calendar days of the date of the invoice, unless the pending applicant provides his or her payment information on the application.

(d) A pending applicant will remain in pending status until the division makes the final eligibility determination. If the individual is determined eligible but has not yet made his or her fast track prepayment, he or she will be considered conditionally eligible until the expiration of the sixty (60) day fast track prepayment period described in subsection (c).

(e) To receive HIP Plus or HIP State Plan Plus benefits, a pending applicant or conditionally eligible individual, as applicable, must make, at his or her option, either:
(1) the fast track prepayment described in subsection (c); or
(2) the initial monthly contribution to his or her POWER account in the amount set forth in SECTION 45(a) of this document;
within the sixty (60) day fast track prepayment period described in subsection (c).

(f) An individual with household income above one hundred percent (100%) of the FPL will:
(1) begin receiving HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes either his or her fast track prepayment or initial POWER account contribution, as applicable, in accordance with subsection (e); or
(2) in the event such individual makes neither the initial fast track prepayment nor the initial POWER account contribution in accordance with subsection (e), the individual will no longer be a pending applicant or conditionally eligible, as applicable.

(g) An individual with household income at or below one hundred percent (100%) of the FPL will:
(1) begin HIP Plus or HIP State Plan Plus benefits, as applicable, the first day of the month in which the individual makes either his or her fast track prepayment or initial POWER account contribution, as applicable, in accordance with subsection (e); or
(2) in the event such individual makes neither the fast track prepayment or the initial POWER account contribution in accordance with subsection (e), the individual will begin HIP Basic or HIP State Plan Basic benefits, as applicable, the first day of the month in which the sixty (60) day prepayment period described in subsection (c) expires.

(h) Subsections (b) through (g) do not apply to an Indian. An eligible Indian will begin HIP Plus or HIP State Plan Plus benefits, as applicable, effective the first day of the month in which the individual applied for the plan.

SECTION 6. **(a) The following individual is eligible for participation in the plan if the individual:**
(1) Is at least nineteen (19) years of age and less than sixty-five (65) years of age, except as set forth in SECTION 9(d) of this document.
(2) Is an Indiana resident.
(3) Is not enrolled in or eligible for enrollment in the federal Medicare program under 42 U.S.C. § 1395 et seq.
(4) Is not eligible for another Medicaid assistance category, except for the following:
(A) Section 1931 parents and caretaker relatives.
(B) Low income dependents, age nineteen (19) or twenty (20) years old.
(C) Transitional medical assistance.
(D) A member who becomes eligible for the pregnant women Medicaid category in accordance with SECTION 11 of this document.
(5) Has household income at or below one hundred thirty-three percent (133%) of the FPL for the applicable family size.

(b) As a condition of eligibility, an individual living with a dependent child less than nineteen (19) years of age must ensure that the child is enrolled in Medicaid, the Children's Health Insurance Program, or otherwise enrolled in minimum essential coverage as defined in 42 CFR 435.4. This condition does not apply to the following:
(1) Section 1931 parents and caretaker relatives.
(2) Transitional medical assistance.
(3) Low income dependents, age nineteen (19) or twenty (20) years old.
(4) Pregnant women.

(c) There is no asset or resource test for the plan.

(d) The office will refer all members or conditionally eligible individuals, who are unemployed or work less than twenty (20) hours per week, to the Indiana department of workforce development for

participation in workforce training programs. The following individuals are exempt from this referral:

(1) Full-time students enrolled in a postsecondary education institution or technical school.

(2) Those individuals who have already been referred to the Indiana department of workforce development for participation in workforce training programs by a governmental agency.

SECTION 7. **(a) Except as otherwise provided in this document, a member in HIP Plus or HIP State Plan Plus must make regular monthly POWER account contributions in the amount set forth in SECTION 45(a) of this document. A member who fails to make his or her POWER account contributions is subject to the actions set forth in SECTION 54(a) of this document, unless the individual is excepted under SECTION 55 of this document.**

(b) A member who is either:

(1) enrolled in HIP Basic or HIP State Plan Basic in accordance with SECTION 4 or 5 of this document; or

(2) transferred to HIP Basic or HIP State Plan Basic in accordance with SECTION 54 of this document;

will not be required to make POWER account contributions but may be required to pay copayments at the time of service delivery in accordance with SECTION 45(b) of this document.

(c) A member will have the opportunity to transfer from HIP Basic to HIP Plus or HIP State Plan Basic to HIP State Plan Plus under the following circumstances:

(1) upon annual renewal as set forth in SECTION 14(g) of this document; and

(2) for a member with a balance remaining in his or her POWER account at the end of the benefit period, upon rollover in accordance with SECTION 47 of this document.

SECTION 8. **(a) Subject to the eligibility requirements under subsection (b) of this SECTION, a member who is determined to have one (1) or more of the conditions outlined under SECTION 2(cc) of this document will be eligible to receive HIP State Plan services.**

(b) An applicant who self identifies as medically frail under SECTION 20(b) of this document will be conditionally eligible for HIP State Plan Plus benefits and will be enrolled in either HIP State Plan Plus or HIP State Plan Basic in accordance with SECTION 4 or 5 of this document, as applicable.

(c) A medically frail member who is enrolled in HIP State Plan Plus must continue making his or her monthly POWER account contributions while the member's medically frail status is verified and, if confirmed as medically frail, during the benefit period. A member who does not continue making monthly POWER account contributions is subject to the nonpayment penalties set forth in SECTION 54 of this document, unless the individual is excepted under SECTION 55 of this document.

(d) A medically frail member in HIP State Plan Basic may choose to enroll in HIP State Plan Plus at annual renewal or prior to the rollover determination as provided in SECTION 7(c) of this document by making POWER account contributions in accordance with SECTION 45(a) of this document.

(e) A member's medically frail status will be redetermined at least annually. If the member is determined not to be medically frail, but still eligible under the plan, such member will no longer receive HIP State Plan benefits and will be transferred to:

(1) HIP Plus if he or she is currently enrolled in HIP State Plan Plus; or

(2) HIP Basic if he or she is currently enrolled in HIP State Plan Basic.

SECTION 9. **(a) An eligible applicant or member who meets the definition for Section 1931 parent and caretaker relative or low income dependent will be enrolled in either HIP State Plan Plus or HIP State Plan Basic in accordance with SECTION 4 or 5 of this document.**

(b) If a member under this SECTION is determined to no longer meet the Section 1931 parent or caretaker relative definition based upon reasons other than those listed in subsection (c) of this SECTION, but is still eligible under the plan, he or she will be transferred to:

(1) HIP Plus if he or she is currently enrolled in HIP State Plan Plus; or

(2) HIP Basic if he or she is currently enrolled in HIP State Plan Basic.

(c) A member who no longer meets the Section 1931 parent and caretaker relative definition because of increased income from employment that results in household income greater than allowed under Section 1931 of the Social Security Act will be eligible to receive transitional medical assistance in

accordance with SECTION 10 of this document.

(d) A member who meets the Section 1931 parent and caretaker relative definition and is sixty-five (65) years old or older while enrolled in the plan will remain eligible for the plan for so long as the member continues to meet the Section 1931 parent and caretaker relative definition under SECTION 2(tt) of this document.

(e) A member who meets the Section 1931 parents and caretaker relatives definition and who:
(1) has not received Medicaid coverage or coverage under the plan within two (2) years of the date in which he or she began receiving HIP State Plan benefits under this SECTION; or
(2) is newly enrolled in the plan and meets one (1) of the exceptions described in SECTION 55 of this document;
is eligible for additional coverage as set forth in SECTION 41(b) of this document.

SECTION 10. **(a) The transitional medical assistance category under the plan is available only to those members listed in SECTION 9(c) of this document.**

(b) The transitional medical assistance category under the plan provides guaranteed HIP State Plan coverage for six (6) months but may last up to twelve (12) months.

(c) A member in the transitional medical assistance category and enrolled in HIP State Plan Plus must make the POWER account contributions in accordance with SECTION 45(a) of this document. A member who fails to make his or her POWER account contributions, regardless of household income, will be transferred to HIP State Plan Basic and will be responsible for paying the copayments at the time of service delivery in accordance with SECTION 45(b) of this document.

(d) A member who is eligible for the transitional medical assistance category shall complete and return a report on a form sent by the division at month three (3), six (6), and nine (9) of the potential twelve (12) month period in order to maintain eligibility for the transitional medical assistance category under the plan.

(e) A member who fails to submit the required report as set forth in subsection (d) of this SECTION to the division at month three (3) or six (6) shall no longer be eligible for the transitional medical assistance category and shall be terminated from the plan at month six (6). A member who fails to submit the required report as set forth in subsection (d) to the division at month nine (9) shall no longer be eligible for the transitional medical assistance category and shall be terminated from the plan at the end of month nine (9). A member who is terminated from the plan based upon his or her failure to submit a required report to the division may reapply to the plan at any time.

(f) A member shall be ineligible to receive coverage under this SECTION at the end of the transitional medical assistance coverage period.

SECTION 11. **(a) A member who becomes pregnant during her benefit period will remain enrolled in the plan unless:**
(1) she elects to transfer to the pregnant women Medicaid category; or
(2) she is pregnant at annual renewal, at which time she will be transferred to the pregnant women Medicaid category.

(b) A pregnant member who remains in the plan as described in subsection (a) will be exempt from cost-sharing, including, but not limited to, the following:
(1) HIP Plus monthly contributions set forth in SECTION 45(a) of this document.
(2) HIP Basic copayments set forth in SECTION 45(b) of this document.
(3) Copayments for nonemergent use of a hospital emergency department set forth in SECTION 29 of this document.
(4) Deductible amounts funded through the member's POWER account.

(c) A pregnant member who remains in the plan as described in subsection (a) will receive enhanced benefits as set forth in the state alternative benefit plans for HIP Plus and HIP Basic members throughout the member's pregnancy and for sixty (60) days of postpartum coverage commencing on the date such individual's pregnancy ends.

(d) An applicant who:
(1) is pregnant at the time of application; and
(2) otherwise meets the HIP eligibility criteria set forth in SECTION 6 of this document;
will not be eligible for the plan, but will be placed in and receive coverage under the pregnant women Medicaid category.

(e) A pregnant woman who either:
(1) is transferred to the pregnant women Medicaid category under subsection (a); or
(2) is placed in the pregnant women Medicaid category under subsection (d);
will receive at least sixty (60) days of Medicaid for pregnant women postpartum coverage commencing on the date such individual's pregnancy ends and ending on the first day of the month following the expiration of the sixty (60) day postpartum period.

(f) This subsection applies to a woman described in subsection (e). Upon the office's receipt of notice of the pregnancy end date, the woman will be considered conditionally eligible for HIP Plus. The woman will be eligible to receive coverage in accordance with the process described in SECTION 4 of this document; however, that the woman's plan benefits shall not begin earlier than the date of the expiration of the postpartum period described in subsection (e).

(g) Beginning the first day of the month following the end of the postpartum period described in subsection (c), a woman who remains enrolled in the plan will:
(1) remain in the same benefit plan but will no longer be eligible for the enhanced pregnancy benefits described in subsection (c);
(2) be subject to any applicable copayment or POWER account contribution requirements under SECTION 45 of this document; and
(3) be subject to the nonpayment penalties described in SECTION 54 of this document.

SECTION 12. **(a) An Indian who meets the eligibility requirements for the plan is not subject to any cost sharing requirements under this document.**

(b) This subsection applies to an Indian who has applied and been determined eligible for the plan prior to April 1, 2015. Such an individual will be enrolled with an insurer and will receive HIP Plus or HIP State Plan Plus benefits in accordance with SECTION 4(f) of this document. Beginning on or after April 1, 2015, an individual described in this subsection may opt-out of the plan at any time and receive fee-for-service coverage as provided under subsection (c).

(c) This subsection applies to an Indian applicant who applies for benefits on or after April 1, 2015, and who has been determined eligible for the plan. Such an individual will be enrolled with an insurer. Such an individual may either:
(1) elect to remain enrolled with an insurer; or
(2) elect to opt-out of the plan to receive fee-for-service coverage by submitting a form provided by the office.

(d) For an individual described in subsection (c), HIP Plus or HIP State Plan Plus coverage begins with an insurer effective the first day of the month in which the individual applied for the plan. If the individual submits the form provided by the office to elect to opt-out of the plan pursuant to subsection (c)(2), his or her fee-for-service coverage will begin the first day of the month following the month in which he or she submitted the request to opt-out.

(e) An Indian's eligibility for the plan will not impact his or her ability to receive services at a qualified Indian Health Service facility.

(f) An Indian who chooses to opt-out of the plan and receive fee-for-service benefits under this SECTION may reenroll in the plan and begin receiving HIP Plus benefits at his or her annual redetermination.

SECTION 13. **The division will determine the applicant's or member's:**
(1) eligibility under the plan; and
(2) POWER account contribution requirements;
by considering the applicant's or member's household and household income as defined in SECTION 2(x) and 2(y) of this document.

SECTION 14. **(a) An individual who is approved to participate in the plan shall be eligible for a twelve (12) month period from the date such individual becomes a member unless the member:**

(1) is terminated from the plan in accordance with SECTION 54 of this document; or

(2) becomes ineligible under the rules established under SECTION 15 of this document.

(b) A member will be subject to an annual renewal process at the end of the benefit period to determine continued eligibility for participation in the plan. A member may be asked to submit documentation necessary for the division to determine eligibility.

(c) If a member does not provide the requested documentation under subsection (b) before the end of the member's twelve (12) month benefit period, the member shall be disenrolled from the plan. However, in accordance with 42 CFR 935.916(a)(3)(iii), within ninety (90) days of the end of the expired benefit period, such individual may submit the requested information to the division without having to reapply for the plan. Such individual will not be eligible to receive services during this ninety (90) day period.

(d) An individual who loses coverage under subsection (c) will not be permitted to reapply for the plan for a period of at least six (6) months from the date of disenrollment unless the individual is:

(1) medically frail;

(2) a Section 1931 parents and caretakers relative;

(3) eligible for transitional medical assistance;

(4) low income dependents, aged nineteen (19) or twenty (20); or

(5) eligible for an exception under SECTION 55(e) of this document.

The process set forth in SECTION 48(b) of this document shall apply to a member disenrolled under this subsection.

(e) At the time of a positive eligibility renewal, a member who is enrolled in:

(1) HIP Plus will remain in HIP Plus unless circumstances have changed that require the member to be transferred to HIP State Plan Plus;

(2) HIP Basic will remain in HIP Basic unless:

(A) the member's household income has increased above one hundred percent (100%) of the FPL and the member is only eligible for HIP Plus;

(B) the member chooses to transfer to HIP Plus in accordance with subsection (g); or

(C) circumstances have changed such that the member is eligible for HIP State Plan Basic;

(3) HIP State Plan Plus will remain in HIP State Plan Plus unless circumstances have changed that require the member to be transferred to HIP Plus; or

(4) HIP State Plan Basic will remain in HIP State Plan Basic unless:

(A) the member's household income has increased above one hundred percent (100%) of the FPL and the member is only eligible for HIP State Plan Plus;

(B) the member chooses to transfer to HIP State Plan Plus in accordance with subsection (g); or

(C) circumstances have changed such that require the member to be transferred to HIP Plus or HIP Basic.

(f) A member who must transfer to HIP Plus because his or her household income has increased above one hundred percent (100%) of the FPL must make the required initial contribution to his or her POWER account within sixty (60) days of the renewal effective date. If the member fails to make the initial POWER account contribution within sixty (60) days of the renewal effective date, he or she will be subject to the nonpayment penalties set forth in SECTION 54 of this document, unless the individual is excepted under SECTION 55 of this document.

(g) A member who is in HIP Basic or HIP State Plan Basic and has household income at or below one hundred percent (100%) of the FPL will have the opportunity at the time of his or her annual renewal to transfer to HIP Plus or HIP State Plan Plus, as applicable, if he or she makes the required initial contribution to his or her POWER account within sixty (60) days of the renewal effective date. If the member fails to make the initial POWER account contribution within sixty (60) days of the renewal date, he or she will remain in HIP Basic or HIP State Plan Basic, as applicable.

SECTION 15. **(a) During the twelve (12) month coverage period, an individual will become ineligible to participate in the plan under the following circumstances:**

(1) The member is no longer an Indiana resident.

(2) The member is enrolled or is otherwise eligible for enrollment in the federal Medicare program

under 42 U.S.C. § 1395 et seq.

(3) The member becomes eligible for another Medicaid assistance category, except for:

(A) Section 1931 parents and caretaker relatives;

(B) low income dependents, age nineteen (19) or twenty (20) years old;

(C) transitional medical assistance; or

(D) pregnant women Medicaid category.

(4) The member has household income above one hundred percent (100%) of the FPL and is terminated under SECTION 54 of this document for failure to make the required POWER account contributions.

(5) The member or the member's duly authorized representative requests in writing that coverage be terminated.

(6) The member falsifies information on the application.

(7) The member is at least sixty-five (65) years of age unless he or she is:

(A) a Section 1931 parent or caretaker relative; or

(B) eligible for transitional medical assistance.

(8) Except for a member eligible for transitional medical assistance, the member's household income exceeds one hundred thirty-three percent (133%) of the FPL.

(b) Coverage will be terminated for an individual who loses eligibility under this SECTION.

SECTION 16. **(a) An individual may apply for presumptive eligibility under the plan. A qualified presumptive eligibility provider will determine whether an individual is eligible for a presumptive eligibility period.**

(b) An individual who is determined presumptively eligible for the plan will be enrolled with an insurer and be provided benefits equivalent to HIP Basic, including applicable copayments as set forth in SECTION 45(b) of this document.

(c) A presumptively eligible individual who does not file an Indiana application for health coverage will receive the presumptive eligibility benefits described in subsection (b) of this SECTION, until the last day of the month following the month in which the determination of presumptive eligibility was made, in accordance with 42 CFR 435.1103.

(d) A presumptively eligible individual whose application for health coverage has been filed and approved by the division will receive the presumptive eligibility benefits described in subsection (b), until one (1) of the following occurs, as applicable:

(1) For a presumptively eligible individual who has paid his or her initial fast track prepayment or POWER account contribution within sixty (60) days of the date of the invoice, in accordance with SECTION 4 or 5 of this document, the presumptive eligibility period will end effective the first day of the month in which the payment was made, and such individual shall begin HIP Plus or HIP State Plan Plus benefits, as applicable, effective the first day of the month in which the payment was made, with no gap in coverage.

(2) For a presumptively eligible individual with household income greater than one hundred percent (100%) of the FPL, who is not otherwise eligible to receive HIP Basic benefits, and who has not paid his or her initial fast track prepayment or POWER account contribution within sixty (60) days of the date of the invoice, in accordance with SECTION 4 or 5 of this document, the presumptive eligibility period will end effective the date in which the office determines nonpayment.

(3) For a presumptively eligible individual with household income below one hundred percent (100%) of the FPL who has not paid his or her initial fast track prepayment or POWER account contribution within sixty (60) days of the date of the invoice, in accordance with SECTION 4 or 5 of this document, the presumptive eligibility period will end effective the first day of the month in which the sixty (60) day payment period expired, and such individual shall begin HIP Basic or HIP State Plan Basic benefits, as applicable, effective the first day of the month in which the sixty (60) day payment period expired, with no gap in coverage.

(e) A presumptively eligible individual whose Indiana application for health coverage has been filed, but not approved by the division, will receive the presumptive eligibility benefits described in subsection (b), until the day on which a decision is made on that application, in accordance with 42 CFR 435.1103.

(f) An individual whose presumptive eligibility period ends in accordance with subsections (c), (d)(2), and (e) will not be enrolled in the plan and may reapply.

(g) An individual shall only be approved for one (1) period of presumptive eligibility within a twelve (12) month period beginning on the date that a qualified presumptive eligibility provider makes an affirmative presumptive eligibility determination.

SECTION 17. **(a) For purposes of SECTIONS 17, 18, and 19 of this document, the term action means any of the following:**

(1) A termination of benefits.
(2) A suspension of benefits.
(3) A change in benefits.
(4) A denial of covered services.
(5) A reduction of covered services.

(b) In the event that the office or the division takes an action that the applicant, pending applicant, conditionally eligible individual, or member believes was undertaken erroneously, such person or entity may request an administrative hearing under 405 IAC 1.1.

(c) Appeals under SECTIONS 17, 18, and 19 of this document are governed by the procedures and time limits set out in 405 IAC 1.1.

SECTION 18. **(a) A pending applicant, conditionally eligible individual, or plan member dissatisfied with the action of an insurer must first exhaust the insurer's internal appeals procedure prior to requesting a hearing with the state.**

(b) After exhausting the insurer's internal appeals procedures, a pending applicant, conditionally eligible individual, or member may request a state administrative hearing with the state no later than thirty-three (33) days from the date of the insurer's resolution of appeal.

(c) The state's hearing process shall be governed by the procedures and time limits set forth in 405 IAC 1.1.

SECTION 19. **(a) This subsection applies to an aggrieved member requesting an administrative appeal under SECTION 17 or 18 of this document.**

(1) If an aggrieved member requests an administrative hearing as provided in the notice of adverse action, prior to the effective date of the adverse action, plan coverage will continue without change until an administrative law judge issues a decision after the hearing under 405 IAC 1.1-1-6. If POWER account contributions were required for that member to receive services, he or she must continue to make contributions to his or her POWER account during the appeal in order to continue coverage.
(2) If the administrative law judge sustains the action, the member is responsible for repaying the cost of any services furnished by reason of this SECTION, minus any POWER account contributions made for coverage during the pendency of the appeal.
(3) If the action under appeal is overturned, the state or the insurer will make coverage available effective to the date the overturned action was taken. However, unless the member is not required to make POWER account payments to maintain coverage, the individual must make any POWER account payments that became due during the appeal within sixty (60) days of the insurer's date of invoice in order to continue participating in the plan.
(4) A member will not receive continued benefits pending the outcome of an administrative hearing if:
(A) the action is the result of the member's nonpayment of POWER account contributions; or
(B) the member requests in writing that plan benefits not be maintained pending the administrative appeal.

(b) This subsection applies to an applicant requesting an administrative appeal under SECTION 17 or 18 of this document. If an applicant was determined ineligible but receives a favorable decision on appeal, coverage begins as follows:

(1) For an applicant who made either a fast track prepayment as provided under SECTION 5(c) of this document or initial POWER account contribution, the first of the month in which the individual made either the fast track prepayment or the initial POWER account contribution.
(2) For an applicant who made neither a fast track prepayment nor an initial POWER account contribution prior to the date of the appealable action, such individual will be given a period of time to make either a fast track prepayment or an initial POWER account contribution. This period of time will be equal to the amount of time remaining in his or her payment period from the date of the office's

erroneous action. Such period begins on the date of the insurer's new invoice issued after the favorable decision on appeal. If the individual makes either a fast track prepayment or POWER account contribution within this period, the individual will receive a coverage start date intended to put such individual in the position he or she would have been in but for the office's erroneous determination.

(c) An aggrieved applicant requesting an administrative appeal under SECTION 17 or 18 of this document who receives a favorable determination and is enrolled in either HIP Plus or HIP State Plan Plus in accordance with subsection (c) must make the required POWER account contributions that accrued during the appeal within sixty (60) days of the date of the invoice in order to continue to be eligible to receive HIP Plus or HIP State Plan Plus coverage. An individual who does not make the required contribution(s) within sixty (60) days of the date of invoice will:

(1) be transferred to HIP Basic or HIP State Plan Basic if the individual is at or below one hundred percent (100%) of the FPL; or

(2) become ineligible for participation in the plan if such individual is above one hundred percent (100%) of the FPL.

SECTION 20. **(a) A member will be reviewed for medically frail status at any of the following times:**

(1) During the verification period if such member's responses on the application questionnaire indicate the potential existence of a medically frail condition.

(2) At any time during the benefit period if documentation demonstrates that the member may have a medically frail condition.

(3) At any time if documentation demonstrates that the member may no longer have a medically frail condition.

(4) At any time upon member request.

(5) For a medically frail member, at least annually by the insurer for continued medically frail eligibility.

(b) The division will forward an applicant's responses to the health screening questions obtained in accordance with SECTION 3(c) of this document to an insurer for verification of medically frail status if:

(1) the division determines the applicant is eligible under the plan; and

(2) the division determines the applicant's responses indicate the possible existence of a medically frail condition.

(c) During calendar year 2015, beginning upon the date an individual identified as potentially medically frail in accordance with subsection (b) becomes a member, the insurer will have a period of sixty (60) days to verify the member's medically frail status. For purposes of this SECTION, this period is referred to as the verification period. Beginning in calendar year 2016, and for each subsequent year of the plan, the verification period shall be reduced to thirty (30) days.

(d) A member will receive HIP State Plan benefits during the verification period and will be enrolled in either HIP State Plan Plus or HIP State Plan Basic in accordance with SECTION 8 of this document.

(e) In order to verify a member's medically frail condition, the insurer shall consider one (1) or more of the following using a process approved by the office:

(1) The member's responses to the application questionnaire.

(2) The member's initial health screen.

(3) The member's health assessment.

(4) Review of medical records.

(5) Review of the member's present or historical medical claims data.

(6) Any other information relevant to the member's health condition.

(f) If the insurer determines that a member is not medically frail or the insurer is unable to verify the member's medically frail status during the verification period, the member will be transferred to either:

(1) HIP Plus if he or she was enrolled in HIP State Plan Plus during the verification period; or

(2) HIP Basic if he or she was enrolled in HIP State Plan Basic during the verification period.

(g) An individual wishing to appeal an insurer's determination under this SECTION must first appeal to the insurer making the determination in accordance with SECTION 18 of this document. If, on appeal to the insurer, the insurer finds that the member is not medically frail, the member may appeal the finding to the state in accordance with SECTION 17 of this document.

(h) The office may review the placement of a member who has been determined to be medically frail to determine whether the placement is appropriate by considering any of the following:

(1) Review of the member's answers to the medically frail screening questions on the application.

(2) Review of the member's medical records.

(3) Communication with or other outreach to the insurer, the member, or the member's provider or providers.

(4) Review of some or all of the member's past claims history, if available and accessible.

(5) Other review processes, as determined by the office.

(i) If, under subsection (h), the office determines that a member is not medically frail, the member will no longer receive HIP State Plan benefits and will be transferred to:

(1) HIP Plus if he or she is currently enrolled in HIP State Plan Plus; or

(2) HIP Basic if he or she is currently enrolled in HIP State Plan Basic.

An individual determined not medically frail under this subsection may appeal the determination directly to the state in accordance with SECTION 17 of this document.

SECTION 21. **For a benefit or service to be covered under the plan, it must be medically necessary as defined in SECTION 2(dd) of this document.**

SECTION 22. **(a) This SECTION outlines the benefits available to an individual enrolled in HIP Basic. The covered services provided under HIP Basic are in accordance with the essential health benefit requirements under 42 CFR 440.347 for alternative benefit plan. The HIP Basic plan includes the coverage criteria, limitations, and procedures specified in this document as well as the HIP Basic alternative benefit plan approved by CMS.**

(b) HIP Basic shall include covered services and benefits in each of the following categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity services.

(5) Mental health and substance abuse services.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive care services.

(10) Early and periodic screening, diagnostic, and treatment (EPSDT) services, as defined at 42 U.S.C. § 1396d(r), will be provided for nineteen (19) and twenty (20) year old HIP Basic members.

(c) The following services are not covered under HIP Basic:

(1) Services that are not medically necessary.

(2) Dental services.

(3) Vision services.

(4) Nonemergency transportation services.

(5) Any other services not approved by CMS in the HIP Basic alternative benefit plan.

SECTION 23. **(a) This SECTION outlines the benefits available to an individual enrolled in HIP Plus. The covered services provided under HIP Plus are in accordance with the essential health benefit requirements under 42 CFR 440.347 for alternative benefit plan. The HIP Plus plan includes the coverage criteria, limitations, and procedures specified in this document as well as the HIP Plus alternative benefit plan approved by CMS.**

(b) HIP Plus shall include covered services and benefits in each of the following categories:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity services.

(5) Mental health and substance abuse services.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive care services.
(10) Vision services.
(11) Dental services.
(12) Early and periodic screening, diagnostic, and treatment (EPSDT) services, as defined in 42 U.S.C. § 1396d(r), for nineteen (19) and twenty (20) year old members.

(c) The following services are not covered under HIP Plus:
(1) Services that are not medically necessary.
(2) Nonemergency transportation services.
(3) Any other services not approved by CMS in the HIP Plus alternative benefit plan.

SECTION 24. **(a) This SECTION outlines services available to a member enrolled in HIP State Plan. All covered services and benefits under HIP State Plan are subject to the coverage criteria, limitations, and procedures specified in this document as well as the benefits specified in the CMS approved Medicaid State Plan.**

(b) HIP State Plan shall include covered services and benefits in the following categories that are equivalent to the Medicaid State Plan:
(1) Ambulatory patient services.
(2) Emergency services.
(3) Hospitalization.
(4) Maternity services.
(5) Mental health and substance abuse services.
(6) Prescription drugs.
(7) Rehabilitative and habilitative services and devices.
(8) Laboratory services.
(9) Preventive care services.
(10) Vision services.
(11) Dental services.
(12) Early and periodic screening, diagnostic, and treatment (EPSDT) services, as defined in 42 U.S.C. § 1396d(r), for nineteen (19) and twenty (20) year old members.

(c) The following services are not covered under HIP State Plan:
(1) Services that are not medically necessary.
(2) Any other services not covered by the CMS approved Medicaid State Plan.

SECTION 25. **Coverage of mental health care services shall be subject to the same treatment limitations or financial requirements as coverage of services for physical illness.**

SECTION 26. **(a) HIP Basic and HIP Plus will provide prescription drug benefits in accordance with 45 CFR 156.122. At a minimum:**
(1) one (1) drug in every United States Pharmacopeia category and class; or
(2) the same number of prescription drugs in each category and class of the essential health benefits benchmark plan;
will be covered.

(b) A HIP Basic member may only access a brand name prescription drug if either:
(1) the insurer approves a prior authorization request for the brand-name drug; or
(2) the individual accesses the drug through step therapy.

(c) Subject to subsection (d), HIP State Plan Plus and HIP State Plan Basic health plans will provide prescription drug benefits in accordance with the requirements of legend drugs in the Medicaid fee-for service program as set forth in 405 IAC 5-24-3.

(d) HIP Basic and HIP State Plan Basic prescription drug coverage:
(1) is limited to a thirty (30) day prescription drug supply; and
(2) is subject to a copayment in accordance with SECTION 45(b) of this document.

(e) HIP Plus and HIP State Plan Plus pharmacy benefits include:
(1) up to a ninety (90) day prescription supply;
(2) mail order pharmacy benefit; and

(3) medication therapy management services.

SECTION 27. **Covered laboratory services include only laboratory services provided by laboratories or providers with Clinical Laboratory Improvement Amendments (CLIA) certificates.**

SECTION 28. **(a) Preventive care services as set forth in 42 U.S.C. § 300gg-13 will be covered, irrespective of whether the member has met his or her deductible, and will not be reimbursed using the member's POWER account.**

(b) Preventive care services not set forth in 42 U.S.C. § 300gg-13 will be covered up to five hundred dollars ($500) during the member's benefit period, irrespective of whether the member has met his or her deductible, and will not be reimbursed using the member's POWER account. Any such services in excess of five hundred dollars ($500), will be covered, but will be subject to the member's deductible and will be reimbursed using the member's POWER account.

(c) A member must receive preventive care services applicable to him or her during the benefit period in order to qualify for the rollover of POWER account funds described in SECTION 47 of this document.

(d) If an insurer determines that a member has not met his or her preventive care requirements during the benefit period, such member may submit documentation to the insurer showing that he or she received the required preventive care services.

SECTION 29. **(a) Except as provided under subsection (g) of this SECTION, a member shall be subject to an eight dollar ($8) copayment for his or her first nonemergency use of a hospital emergency department and a twenty-five dollar ($25) copayment for each subsequent nonemergency use of a hospital emergency department during the benefit period.**

(b) The following members are exempt from paying the copayments described under subsection (a) or subsection (g):
(1) Pregnant women.
(2) Indians.
(3) An individual who meets the requirements of SECTION 45(f) of this document.

(c) The copayments described under subsection (a) of this SECTION shall not apply if:
(1) the member is found to have an emergency medical condition;
(2) the member is admitted to the hospital within twenty-four (24) hours of the emergency department visit; or
(3) the member contacted his or her insurer's twenty-four (24) hour nurse hotline prior to seeking services from a hospital emergency department.

(d) A hospital provider must conduct an appropriate medical screening examination as provided under 42 U.S.C. § 1395dd prior to rendering any medical services. If the provider determines that the member does not have an emergency medical condition, the provider must inform the member of the informational requirements under 42 U.S.C. § 1396o-1(e) prior to rendering any medical services.

(e) Hospital providers shall be responsible for collecting emergency room copayments incurred under this SECTION.

(f) A member may not use his or her POWER account to pay for emergency room copayments incurred under this SECTION.

(g) Beginning May 1, 2015, and effective through January 31, 2017, and under the approval of CMS, the office may exempt randomly selected members from the graduated copayment requirement described in subsection (a). This group shall consist of no fewer than five thousand (5,000) members. Such members shall be subject to an eight dollar ($8) copayment for each nonemergency use of a hospital emergency department during the benefit period. Subsections (a) through (f) shall apply to this group.

SECTION 30. **The following services are covered under the plan, even if provided out-of-network:**
(1) Family planning services.
(2) Emergency services.
(3) Medically necessary covered services if the member's insurer is unable to provide the services in

network within:

(A) thirty (30) miles of the member's residence for primary care; and

(B) sixty (60) miles of the member's residence for specialty care.

(4) Nurse practitioner services that are medically necessary covered services provided within the scope of the nurse practitioner's applicable license and certification.

(5) Medically necessary covered services provided at a federally qualified health center (FQHC) or rural health clinic (RHC).

SECTION 31. **(a) A member may receive the following covered services without a referral from his or her primary medical provider or prior authorization or precertification from his or her insurer:**

(1) Family planning services.

(2) Emergency services.

(b) A member may receive the following services without a referral from his or her primary medical provider, provided the service is a covered service under such member's benefits package and subject to any requirements established by the insurer regarding the use of in-network providers:

(1) Psychiatric services provided by a provider licensed under IC 12-15-11.

(2) Behavioral health services.

(3) Immunization services.

(4) Diabetes self-management training services, as set forth in IC 27-8-14.5-6.

(5) Chiropractic services.

(6) Eye care services, except for surgical services on the eye.

(7) Podiatric services.

(8) Urgent care services.

SECTION 32. **(a) An insurer may implement utilization control procedures, including prior authorization or precertification of services as provided under 42 CFR 438.210. The following services are exempt from prior authorization:**

(1) Emergency services, subject to the requirements of SECTION 29 of this document.

(2) Family planning services.

(3) Urgent care.

(b) A provider that:

(1) has an agreement with the office; and

(2) renders services to a member;

must follow the utilization control procedures implemented by the insurer under subsection (a) of this SECTION whether or not that provider has a contract with the insurer.

(c) Insurers shall make decisions regarding prior authorization and precertification in accordance with the requirements of 405 IAC 5-3-14.

SECTION 33. **(a) Insurers and providers shall not charge, collect, or impose cost sharing, including premiums, copayments, or coinsurance to plan members for covered services, except in the following circumstances:**

(1) Deductible amounts paid for with funds out of a member's POWER account.

(2) Emergency room copayments, as set forth in SECTION 29 of this document.

(3) Copayments, as set forth in SECTION 45(b) of this document.

(b) In those instances where the insurer pays for a service at the Medicare rate, any cost sharing that would typically be applicable in the Medicare program:

(1) is not applicable; and

(2) will be included in the rate paid by the insurer.

(c) Notwithstanding subsection (a) of this SECTION, insurers and providers shall not charge, collect, or impose cost-sharing, including premiums, copayments, or coinsurance, for any covered service to a member who is:

(1) pregnant; or

(2) an Indian.

SECTION 34. **(a) A member shall remain enrolled with the same insurer during the member's benefit period. A member may change insurers upon request only in the following circumstances:**

(1) Without cause before making his or her fast track prepayment or initial POWER account contribution or within sixty (60) days of being assigned to an insurer, whichever comes first.
(2) For cause at any time. A member under this subsection may request to change insurers at any time by submitting a grievance to the insurer and receiving the insurer's or the division's approval.
(3) Without cause, at renewal, if the member submits the request to change insurers to the enrollment broker at least forty-five (45) days prior to the end of the member's benefit period.
(4) A member in the pregnant women Medicaid category may request to change insurers through the enrollment broker at any time during her pregnancy.

(b) For purposes of subsection (a)(2), "for cause" has the meaning set forth in 42 CFR 438.56(d)(2) and includes, but is not limited to, any of the following:
(1) Receiving poor quality care.
(2) Failure of the insurer to provide covered services.
(3) Failure of the insurer to comply with established standards of medical care administration.
(4) Lack of access to providers experienced in dealing with the member's health care needs.
(5) Significant language or cultural barriers.
(6) Corrective action levied against the insurer by the office.
(7) Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence.
(8) A determination that another insurer's formulary is more consistent with a new member's existing health care needs.
(9) Other circumstances determined by the office or its designee to constitute poor quality of health care coverage.

(c) A member who receives an unfavorable decision from the insurer under subsection (a)(2) may submit a request for reconsideration pursuant to the instructions in the insurer's notice of decision. A request for reconsideration will be deemed approved if official action is not taken on the request by the first day of the second month following the month in which the individual submits the request. A member who files a grievance with the insurer and completes the reconsideration process will be considered to have met the requirements of SECTION 18 of this document for purposes of filing an appeal with the state.

SECTION 35. **The insurer shall maintain and monitor an adequate network of providers in accordance with 42 CFR 438.206. The insurer shall not maintain network differentiation between its HIP Plus and HIP Basic benefit plans.**

SECTION 36. **(a) With the exception of emergency services providers, a provider rendering covered services to a member must be enrolled in the Indiana Medicaid program at the time of service in order to receive reimbursement. An emergency services provider who is not enrolled in the Indiana Medicaid program at the time of service must enroll in the Indiana Medicaid program retroactive to the date of service in order to receive reimbursement.**

(b) In order to enroll as a provider as required under subsection (a), the provider must comply with the procedures set forth in 405 IAC 5-4-1.

(c) A provider providing covered services to members shall provide the services under a contract with an insurer except in the following circumstances:
(1) If the service provided is listed in SECTION 30 of this document.
(2) If the insurer:
(A) has designed an out-of-network benefit for its members; or
(B) otherwise approves the out-of-network service.

SECTION 37. **(a) The right of providers contracting with insurers to dispute any actions taken by the insurer is governed by the provider's contract with the insurer.**

(b) The reimbursement dispute resolution procedure set forth at 405 IAC 1-1.6 shall apply to providers who do not have a contract with an insurer for services provided under the plan.

(c) Any provider disputes involving prior authorization determinations made by the insurers are governed by the insurers' procedures for provider grievances and appeals.

(d) A contracted or noncontracted provider shall have no right to appeal an insurer's action to the state.

SECTION 38. **(a) Except as provided in subsection (b), before providing any nonemergency service covered under the plan, a provider must verify all of the following:**

(1) The individual is eligible for the plan.

(2) The individual is enrolled with an insurer.

(3) The individual is enrolled in the plan at the time the service is being provided.

(4) The individual whose name appears on the card is the same individual for whom the service is being performed.

(5) The service is covered under the member's benefit plan.

Failure to do so may result in denial of the provider's claim if the individual is not enrolled in the plan or the service is not authorized.

(b) Hospitals providing services to individuals during the presumptive eligibility period in accordance with SECTION 16(c), 16(d), or 16(e) of this document are exempt from the requirements of subsection (a)(1) and (a)(2). Such hospitals must verify that the individual is eligible for presumptive eligibility under SECTION 16(a) of this document.

(c) If an individual is disenrolled from an insurer while receiving inpatient hospital services covered under the plan, the insurer shall pay any claims related to the covered inpatient hospital services provided to the member through the date of discharge.

SECTION 39. **The provisions of 405 IAC 1-5-1 and 405 IAC 1-5-2 concerning contents, retention, and disclosure of records apply to providers under this document.**

SECTION 40. **(a) Reimbursement matters including:**

(1) the time limit for filing claims; and

(2) rates paid to providers contracting with insurers;

are governed by the contract between the provider and the insurer.

(b) Reimbursement rates paid by insurers to providers without contracts who render services to plan members shall be at plan reimbursement rates governed by IC 12-15-44.2-14(a)(2).

(c) No provider retains any independent or duplicative right for reimbursement from the office in addition to or in lieu of reimbursement received from the insurer.

SECTION 41. **(a) A provider shall be reimbursed for covered services as follows:**

(1) Until the member's deductible is met, with POWER account funds accessed through the member's POWER account and paid by the insurer. If the member lacks sufficient POWER account funds at the time of service, the insurer must pay for any portion of the plan reimbursement rate that cannot be paid with POWER account funds but shall reconcile these prepaid amounts as additional POWER account funds are received from the member.

(2) For all covered preventive care services, which are not subject to the member's deductible, by the insurer.

(3) For covered services under the member's health plan after the deductible has been met, by the insurer.

The provider shall be reimbursed at the plan reimbursement rate.

(b) Reimbursement is not available for services provided to individuals who are not enrolled in the plan on the date the service is provided except as provided under the following:

(1) To those individuals whose coverage dates back to the first of the month as outlined in SECTION 4 or 5 of this document.

(2) To an individual in accordance with SECTION 38(b) and 38(c) of this document.

(3) To a member described in SECTION 9(e) of this document who:

(A) did not gain coverage through presumptive eligibility as set forth at SECTION 16 of this document;

(B) received a covered service no later than ninety (90) days prior to the date he or she was determined eligible for the plan by the division; and

(C) had a claim submitted on his or her behalf by a provider seeking reimbursement for the service identified in subsection (B) within ninety (90) days after his or her receipt of a bill for such service.

(c) The plan reimbursement rate defined in SECTION 2(kk) of this document does not include:
(1) critical access hospital payments;
(2) graduate medical education payments; or
(3) disproportionate share hospital payments.

(d) Insurers shall reimburse federally qualified health centers (FQHCs) and rural health clinics (RHCs) for covered FQHC and RHC services at the Medicare all-inclusive rate for each visit, as established by the Medicare fiscal intermediary and according to Medicare policy. In the event the amount paid by insurers is less than the amount set forth in 42 U.S.C. § 1396a(bb), the office shall make a supplemental payment in accordance with 42 U.S.C. § 1396a(bb)(5).

SECTION 42. **A provider must accept plan reimbursement as payment in full. A provider cannot collect from a member any portion of the provider's charge for a covered service that is not reimbursed by the insurer, with the exception of the following:**
(1) Emergency room copayments authorized under this document.
(2) Payments made with POWER account funds before the deductible of the member's health plan is met.
(3) Copayments authorized under SECTION 45(b) of this document.

SECTION 43. **(a) The insurer shall establish and administer a POWER account in the name of each individual enrolled in the plan. The maximum amount that may be contributed to the POWER account is two thousand five hundred dollars ($2,500) per year, contributed as specified under SECTION 46 of this document.**

(b) POWER account funds must be used to pay the deductible for health care services covered under the plan.

(c) A member will not keep interest earned on his or her POWER account.

SECTION 44. **(a) Each member is responsible for his or her use of funds in his or her POWER account until the deductible is met. A member's POWER account funds can only be used to pay for covered services and shall not be used to pay the following:**
(1) The emergency room services copayment described in SECTION 29 of this document.
(2) HIP Basic copayments as set forth in SECTION 45(b) of this document.
(3) Any other cost not covered in the member's specific benefit package as listed in SECTIONS 22, 23, or 24 of this document.

(b) Members may use POWER account funds to pay for covered out-of-network services described in SECTION 30 of this document.

SECTION 45. **(a) A member enrolled in either HIP Plus or HIP State Plan Plus is required to contribute a monthly amount to his or her POWER account. Except as provided in subsection (g), a member's monthly POWER account contribution is determined by multiplying a member's annual household income by two percent (2%) and dividing by twelve (12). In no event shall the member's monthly POWER account payment exceed one hundred dollars ($100) per month or be less than one dollar ($1) per month.**

(b) Except as provided under subsection (c), a member enrolled in HIP Basic or HIP State Plan Basic is not required to make monthly contributions to his or her POWER account but will be charged a copayment at the time services are rendered, as follows:
(1) Four dollars ($4) for outpatient services.
(2) Seventy-five dollars ($75) for inpatient services.
(3) Four dollars ($4) for preferred drugs.
(4) Eight dollars ($8) for nonpreferred drugs.

(c) The following members are not subject to cost sharing under this SECTION:
(1) An Indian.
(2) Pregnant woman.
(3) Any individual who meets the requirements in subsection (f).

(d) No copayment is required for the following services:

(1) Preventive care services.
(2) Family planning services.
(3) Maternity services.

(e) A provider is responsible for collecting the required copayments at the time services are provided. A provider may not deny a service to a member if such member is unable to pay the copayment at the time of service delivery. If a member does not pay the copayment at the time services are provided, the member is still responsible to pay the copayment and the provider may bill the member for the copayment amount owed.

(f) A member's out-of-pocket cost sharing amount shall not exceed five percent (5%) of his or her annual household income in accordance with 42 CFR 447.48, except that all HIP Plus members whose household income is at or below five percent (5%) of the FPL will be required to contribute, at a minimum, monthly one dollar ($1) POWER account contributions.

(g) In a family with two (2) or more members, each member will have his or her own POWER account established in accordance with SECTION 43 of this document, but the total of both members' required POWER account contributions cannot exceed two percent (2%) of the monthly household income, subject to the one dollar ($1) minimum contribution amount set forth in subsection (f).

SECTION 46. **(a) The state shall contribute the difference between:**
(1) the member's annual contribution; and
(2) two thousand five hundred dollars ($2,500).

(b) Amounts, as specified by the office, may be contributed to a member's POWER account by:
(1) a member;
(2) a member's employer, if the contribution is not from funds payable by the employer to the employee;
(3) any third party, subject to the restrictions in subsection (d); or
(4) the insurer, under which the member is enrolled, if the payment:
(A) is to provide a health incentive to the member; and
(B) does not count toward the member's required contributions as set forth in SECTION 45(a) of this document.

(c) In no event shall a member's POWER account balance exceed two thousand five hundred dollars ($2,500).

(d) A health care provider or provider-related entity may make a contribution to a member's POWER account in accordance with subsection (b)(3), provided:
(1) the provider or provider related entity establishes criteria for providing assistance that do not distinguish between individuals based on whether or not they receive or will receive services from the contributing provider or providers or class of providers; and
(2) the provider or provider related entity does not include the cost of such payments in either the cost of care for purposes of Medicare and Medicaid cost reporting or included as part of a Medicaid shortfall or uncompensated care for any purpose.

SECTION 47. **(a) For a member who remains eligible for the plan at the end of the benefit period, the state will recalculate such member's POWER account contribution as part of the renewal process. This may occur after the new benefit period has begun. POWER account contributions recalculated pursuant to this SECTION are effective the first day of the month following the recalculation.**

(b) A member enrolled in HIP Plus or HIP State Plan Plus with a balance remaining in his or her POWER account at the end of the benefit period may be eligible to rollover a portion of the account balance to reduce such member's POWER account contributions for the new benefit period.

(c) If a member enrolled in HIP Plus or HIP State Plan Plus has met his or her preventive care services goals as set by the office for the expiring benefit period as set forth in SECTION 28 of this document, his or her final rollover amount shall be calculated as follows:
(1) The member's portion is determined by adding the member's required annual contribution for the expiring benefit period to any balance rolled over from previous benefit periods and dividing that sum by two thousand five hundred dollars ($2,500).

(2) The base rollover amount is determined by multiplying the member's portion as determined in subdivision (1) by any remaining balance in the POWER account.

(3) The final rollover amount is determined by multiplying the base rollover amount as determined in subdivision (2) by two (2).

(d) If a member enrolled in HIP Plus or HIP State Plan Plus has not met his or her preventive care services goals as set by the office for the expiring benefit period as set forth in SECTION 28 of this document, his or her final rollover amount shall be calculated only in accordance with subsection (c)(1) and (c)(2). Such member's base rollover amount shall not be multiplied by two (2).

(e) A HIP Basic or HIP State Plan Basic member with a POWER account balance remaining at the end of the expiring benefit period will be eligible to receive a discount on the POWER account contribution such member would need to make in order to be enrolled in the HIP Plus or HIP State Plan Plus plan for the new benefit period. The HIP Plus discount for a HIP Basic or HIP State Plan Basic member with a POWER account balance shall be calculated as follows:

(1) Divide the remaining balance in the POWER account by two thousand five hundred dollars ($2,500). If the resulting percentage is less than or equal to fifty percent (50%), then that percentage will be used in subdivision (2). However, if the resulting percentage is greater than fifty percent (50%), then the percentage will be capped at fifty percent (50%) for purposes of subdivision (2).

(2) Multiply the required POWER account contribution for the current benefit period by the percentage calculated in subdivision (1).

(3) Subtract the product calculated in subdivision (2) from the POWER account contribution for the current benefit period.

(f) The insurers may collect member debt, if any, as calculated under SECTION 49 of this document, from the member portion of rollover funds calculated in either subsection (c), (d), or (e). The resulting amount shall reduce the member's annual POWER account contribution for the new benefit period. No state rollover funds may be used to pay member debt.

(g) The insurer will reconcile a member's POWER account for the rollover process described in this SECTION no later than one hundred twenty (120) days after the end of the benefit period. A member who remains enrolled in HIP Basic or HIP State Plan Basic at the time he or she receives notice of the amount of the discount set forth in subsection (e) shall have a period of sixty (60) days from the date of such notice to transfer to HIP Plus or HIP State Plan Plus by making a POWER account contribution at the new discounted rate.

(h) In the event the amount of the member's POWER account balance that is rolled over at the end of the benefit period exceeds the amount of the member's annual POWER account contribution for the new benefit period, the member shall not receive a refund of the excess amount. The excess funds shall be returned to the office.

SECTION 48. **(a) If a member loses plan eligibility due to either:**

(1) nonpayment of POWER account contributions as specified in SECTION 54 of this document; or

(2) noncompliance with redetermination processes as specified in SECTION 14 of this document;

the member shall be paid only a portion of the balance remaining in his or her POWER account as calculated in subsection (b).

(b) If a member loses plan eligibility for reasons set forth in subsection (a), the member refund shall be calculated as follows:

(1) Divide the total contributions made on the member's behalf in accordance with SECTION 46(b) of this document during the current benefit period by the total amount paid into the POWER account from all sources.

(2) Multiply the ratio calculated in subdivision (1) by the total amount remaining in the individual's POWER account.

(3) Subtract member debt, if any, as calculated under SECTION 49 of this document.

(4) Multiply the amount calculated in subdivision (3) by seventy-five hundredths (.75) to determine the amount to be returned to the individual.

(c) If a member loses plan eligibility for reasons other than set forth in subsection (a), the member shall be paid a portion of the balance remaining in his or her POWER account, calculated as follows:

(1) Divide the total contributions made on the member's behalf in accordance with SECTION 46(b) of

this document during the current benefit period by the total amount paid into the POWER account from all sources.
(2) Multiply the amount calculated in subdivision (1) by the total amount remaining in the member's POWER account to determine the amount to be returned to the individual.
(3) Subtract member debt, if any, as calculated under SECTION 49 of this document.

(d) The insurer must return the amount calculated in subsection (b) or (c) to the member within sixty (60) days of the member's last date that the individual was a member in the plan. The former member will be liable for the POWER account portion of any claims for covered services with dates of service occurring during the prior benefit period but after the POWER account balance has been paid to the former member. The former member will not be liable for claims originally denied but overturned on appeal if the appealed claim is paid more than sixty (60) days following the member's last date of participation in the plan.

(e) After payment to the member of the amount calculated in subsection (b) or (c), the state shall retain any remaining POWER account balance.

(f) In the event that a member:
(1) cannot be located; or
(2) otherwise does not claim the amount calculated in subsection (a) or (b);
such amount shall be treated as unclaimed property and shall be subject to the Unclaimed Property Act, IC 32-34.

SECTION 49. **(a) For purposes of this SECTION, "debt" means amounts that accrue as a result of:**
(1) an insurer's advance payment of the member's portion of the deductible as provided under SECTION 41(a)(1) of this document that has not been repaid through the member's POWER account contributions; or
(2) any nonsufficient funds check charges resulting from a member's payments to an insurer as a result of payment processing.

(b) A member's debt under subsection(a)(1) shall be calculated as follows:
(1) Divide the member's annual POWER account contribution amount by two thousand five hundred dollars ($2,500).
(2) Multiply the amount of claims paid up to two thousand five hundred dollars ($2,500) during the benefit period by the amount determined in subdivision (1).
(3) Subtract the total monthly individual contributions paid by the member during the benefit period by the amount determined under subdivision (2).

(c) A member's debt under this SECTION shall not exceed the following amounts:
(1) For a member with household income above one hundred percent (100%) of the FPL, an amount that does not exceed ten percent (10%) of the cost of services received.
(2) For a member with household income at or below one hundred percent (100%) of the FPL, an amount that does not exceed the maximum cost-sharing amounts for such individual pursuant to 42 CFR 447.52.

(d) In some cases, the two thousand five hundred dollar ($2,500) deductible will be met before a HIP Plus or HIP State Plan Plus member has made all of his or her required contributions. The fact that a member has not yet made all required POWER account contributions does not relieve the insurer of the responsibility to pay providers for covered services rendered. An insurer may deduct amounts a member owes from future POWER account contributions.

(e) If a member ends participation in the plan before the conclusion of his or her twelve (12) month benefit period and the individual has debt, the insurer may collect from the individual. All collection activities must be approved by the office.

SECTION 50. **A member must promptly report any change that may affect the member's continued eligibility in the plan, including any of the following qualifying events:**
(1) change in family status that results in an increase or decrease in the number of individuals in the member's household; or
(2) any change in employment status or household income.

SECTION 51. **A member must, at a minimum, make the required POWER account contribution within sixty (60) days from the first day of the coverage month for which the POWER account contribution is owed each month to remain eligible. Any excess payments a member pays in a given month will offset the following months' payments.**

SECTION 52. **(a) An employer or other third party, as outlined in SECTION 46(b)(3) of this document, may contribute up to one hundred percent (100%) of a member's annual POWER account obligation. If such an entity contributes less than a member's annual POWER account obligation, such amount will be applied to the member's next due POWER account payment. Any excess amount will be carried over from month-to-month until it is exhausted. A member will be responsible for paying any balance in a given month.**

(b) Any contribution received from an employer or other third party, as outlined in SECTION 46(b)(3) of this document, must be used to offset the member's required POWER account contribution only, and will not be used to offset the state's contribution to the POWER account set forth in SECTION 46(a) of this document.

SECTION 53. **(a) If a member's first POWER account contribution for a new benefit period becomes due before the division calculates the member's new POWER account contribution, the insurer may bill the member in the amount of the POWER account contribution for the previous benefit period.**

(b) Any overpayments or underpayments a member makes as a result of subsection (a) shall be reconciled within thirty (30) days of notification by the state of the member's recalculated POWER account contribution amount for the new benefit period. An overpayment or underpayment may impact a member's future POWER account obligations as a result of subsection (a) of this SECTION.

SECTION 54. **(a) A HIP Plus or HIP State Plan Plus member who does not make a required monthly POWER account contribution within the time frame established in SECTION 51 of this document will receive a notice of nonpayment. Upon receiving a notice of nonpayment:**

(1) except as provided in SECTION 55 of this document, a member with household income above one hundred percent (100%) of the FPL shall be:

(A) terminated from participation in the plan; and

(B) not allowed to reapply for a period of six (6) months from the notice of nonpayment; or

(2) a member with household income at or below one hundred percent (100%) of the FPL shall be:

(A) transferred to HIP Basic, if previously enrolled in HIP Plus; or

(B) transferred to HIP State Plan Basic, if previously enrolled in HIP State Plan Plus.

(b) Any funds remaining in the POWER account of a member terminated pursuant to subsection (a)(1) shall be credited to the state and returned to the individual as provided in SECTION 48(b) of this document.

(c) A member who voluntarily withdraws from the plan:

(1) is subject to subsection (b); and

(2) except as otherwise provided in SECTION 55 of this document, may not reapply to the plan for a period of six (6) months from the date of withdrawal from the plan.

SECTION 55. **(a) A member exempt from cost-sharing pursuant to SECTION 45(d) of this document shall not be subject to any of the nonpayment penalties set forth in SECTION 54(a) of this document.**

(b) A medically frail individual with household income over one hundred percent (100%) of the FPL will not be subject to disenrollment for nonpayment under SECTION 54(a)(1) of this document, but will:

(1) remain in HIP State Plan Plus;

(2) be required to pay copayments as set forth in SECTION 45(b) of this document; and

(3) continue to be billed for monthly POWER account contributions and accrue debt to the insurer.

(c) A member disenrolled pursuant to SECTION 54(a) of this document or SECTION 14 of this document may request a medically frail screening from his or her former insurer in accordance with SECTION 20(e) of this document. If the former member is confirmed as medically frail, he or she may be reinstated to the plan prior to the expiration of the six (6) month lock out period, if he or she files a new application.

(d) A member eligible for transitional medical assistance with household income over one hundred percent (100%) of the FPL will not be subject to disenrollment for nonpayment under SECTION 54(a)(1) of this document, but will transition to HIP State Plan Basic for the duration of his or her transitional medical assistance period in accordance with SECTION 10(c) of this document.

(e) A member disenrolled under SECTION 54(a) or SECTION 14 of this document shall not be subject to the six (6) month lock-out period but may be reinstated to the plan prior to the expiration of the six (6) month lock-out, if a new application is filed and the individual can provide verification that one (1) of the following qualifying events caused the disenrollment:

(1) Obtained and subsequently lost private insurance coverage.

(2) Had a loss of income after disqualification due to increased income.

(3) Took up residence in another state and later returned.

(4) Is a victim of domestic violence.

(5) Was residing in a county subject to a disaster declaration made in accordance with IC 10-14-3-12 at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan.

SECTION 56. **Members shall receive a membership card upon enrollment in the plan. A member may only use his or her membership card for approved plan benefits delivered by approved providers.**

SECTION 57. TEMPORARILY REPEALS 405 IAC 9.

SECTION 58. This document takes effect February 1, 2015.

SECTION 59. This document expires April 30, 2015.

LSA Document #15-38(E)
Filed with Publisher: January 30, 2015, 10:38 a.m.

Posted: 02/04/2015 by Legislative Services Agency
An html version of this document.